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## Psychiatric Problems in General Practice

### A Symposium

THE FOLLOWING PRESENTATIONS were intended as an aid to medical practitioners other than psychiatrists for a better understanding and handling the various psychiatric problems that they might meet in their practices.

Originally presented jointly by the Southern California Psychiatric Society, district branch of the American Psychiatric Association, and the General Practice Section of the Los Angeles County Medical Association as a postgraduate seminar in 1957, it was so well received that it was felt that practitioners throughout the state could find the material of interest and use.

### Psychopharmacology of Drugs

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SO MUCH PUBLICITY has been given to the so-called new miracle tranquilizer drugs—those “happiness” pills which promise release from anxiety and tension—that it is well to recall that there is nothing new either in the use of such drugs or in the susceptibility of the public to trust in their promise. At least as old as recorded history is the use of depressants, euphorics and hallucigens for the temporary relief of tension, and of excitants for stimulation of energy and mood. While pharmacology has given us a whole new host of synthetics as well as

chemical refinements of ancient drugs and improved methods of extraction, it has not as yet introduced any new natural agent in this drug group that was not already known to primitive man.

Since the subject here discussed is the psychopharmacology of drugs, no attempt will be made to define or differentiate in detail between the various chemical properties of the drugs mentioned. My purpose, rather, is to examine these drugs as they are used to affect or bring changes in the psychological homeostasis of the patient. No responsible physician, certainly, would minimize the important role that the tranquilizer drugs have in the treatment of emotional disturbances. They have brought relief from anxiety; they have reduced or eliminated violent behavior in agitated patients; they have often made patients amenable to therapy who could not before be reached. But they have not cured—nor are they likely to do so. Intelligently used, they can be an effective aid in treatment. Used indis-

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criminally, they can precipitate psychological as well as physiological catastrophe.

By far the most dramatic results with these drugs have been achieved in mental hospitals where psychotic patients have frequently shown astonishing improvement when given them. The judicious use of tranquilizing drugs, along with proper supervision by the hospital staff or a physician treating a patient at home has been of incalculable value. It is in the use of these drugs as they are prescribed to effect a change in the psychophysiological state of the outpatient that greater caution must be exercised. The largest number of outpatients who are treated by physicians for psychogenic disturbances fall, loosely, into a group whose emotional maladaptations are due to unresolved unconscious conflicts and who attempt to resolve these unconscious emotional conflicts in a manner that handicaps their effectiveness in living. They may have tension, depression, increased excitability of the nervous system, anxiety, headaches, generalized pains, weakness, dizziness or palpitations.

The prescribing of tranquilizing drugs for such patients is directed toward the alleviation of these symptoms by their depressant action upon the central nervous system. While the drugs may achieve the therapeutic aim of relieving, temporarily, the symptoms, in no way do the drugs attack the problems which precipitated the symptoms. The magic pill which will solve personal problems has not yet been invented. Resolution of a problem demands thought. Drugs relieve some of the feelings and distress that come with thinking. Indeed, a sufficiently high dosage can make it impossible to think at all. But when the drug is withdrawn, feelings and thinking return. Unless the problem which precipitated the symptoms has been attacked, nothing has been accomplished except to give the patient for a short period a feeling of self-transcendence. When tranquilizers are prescribed for patients, it is important that, concurrently, some form of therapy be attempted. This does not mean that the patient must be under the care of a psychiatrist, but it does mean that with the writing of a prescription for a tranquilizing drug, the physician should allow for time in which the patient can ventilate about his problems.

Of the tranquilizers, the phenothiazines and rauwolfia drugs have been the most effective in reducing psychological tensions. Both are depressants and have many properties in common, although their clinical effects, in large dosages, are often dissimilar. Both drugs can produce a variety of side effects which can be relieved either through reduction of dosage or withdrawal of the drug. Because of the depressant action of both these drugs upon the sympathetic nervous system, they should never

be prescribed for depressed states. Since both drugs can also induce depression, it is important that the patient be closely supervised by the physician and that the physician allow sufficient time during office visits to understand what is going on emotionally with the patient. Drug-induced depressions can be alleviated by dosage reduction or withdrawal of the drug. In cases of severe depression, electric shock may be necessary.

The meprobamates and the diphenyl methanes are likewise depressants but because they have relatively few side effects are the most widely used in everyday practice. Recommended for "milder states of nervous system hyperactivity" they can, when used in large dosages, produce drowsiness, dizziness, nausea, blurring of speech and impairment of muscular coordination and of motor responses. They can decrease the patient's ability to concentrate. In smaller dosage they produce less intense effects; and because there is a relative absence of toxic and allergic side effects, patients often yield to the temptation of using them indiscriminately, to say nothing of passing them on to a neighbor.

Another group of drugs all too frequently used to produce changes in consciousness or emotional equilibrium are the amphetamines. The amphetamines, to my mind, require very careful examination as to the psychological repercussions following their use. At first the amphetamines bring about a feeling of well being: Fatigue fades; a swell of energy surges through the body; depression is lifted; the spirit soars, and temporarily, there is a feeling of self-transcendence. (These effects have been achieved from time immemorial through the use of opium and hashish, yet rare is the user of an amphetamine who would not be shocked to have his dependence on the amphetamine compared with resorting to these more ancient drugs. The difference is only one of degree; at best we can only say that the amphetamine is less harmful.) As the amphetamine wears off, it is followed by depression, fatigue, and insomnia often severe enough to require sedation. Very soon patients using amphetamines find that dosage must be increased and a vicious cycle of stimulating oneself during the day and resorting to sedation at night begins.

Fatigue is a signal that the body requires rest. The amphetamine eliminates this signal without restoring to the body the necessary ingredients for renewed energy, and, in fact, stimulates the tired mechanism of the organism to efforts for which natural energy is absent. Resorting to amphetamines to combat fatigue is not unlike putting ethyl alcohol or ether into a worn motor. It may make a car run effectively for a short time, but very soon the cylinders will give way.

This is not to say that there are not times when good medical practice indicates the need for amphetamines. My objection is to the use of them in such a way as to obscure a psychological problem.

Just as fever is an indication that something is wrong with the functioning of the physiological mechanism of the body, so are anxiety, depression, fatigue or prolonged insomnia signals of increased "fever" in the psychological mechanism. Just as fever ought not be alleviated without effort to determine the cause, so these signals must be examined and evaluated before chemotherapy to reduce or eliminate them are prescribed.

Tension, frustration and anxiety have existed in all ages and in all cultures, and probably will continue to plague us so long as man strives. The goal of chemotherapy and psychotherapy cannot then be to eliminate these feelings and reactions merely for

the sake of achieving tranquillity, unless we are prepared to produce human vegetables.

The goal of therapy, whether chemical or psychological, should not be merely to effect a state of blissfulness. The goal, rather, should be to use all the therapeutic tools at hand to enable men and women to participate actively in their environment and to cope with the realities of that environment. A sense of well-being cannot for long be achieved by obscuring the presence of conflicts and dangers, but only by recognizing and dealing with them. The patient must learn how to use his energies toward handling conflicts, removing them when possible, or changing those areas which create threatening situations for him. And through it all, he must learn how to cope with his feelings as he is reacting to his environment.

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## Psychiatric Emergencies

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HEIGHTENED INTEREST in the early recognition and prompt treatment of psychiatric emergencies in medical practice has come in part from the changing pattern of medical illnesses dealt with by general physicians, who now less often treat acute infectious inflammatory diseases and more often of the intermittent disabling illnesses consisting mostly of psychosomatic disorders, emotional states and geriatric problems. These illnesses are most frequently seen initially by physicians in general practice, who are in a most strategic position to serve as a first line of defense against acute psychiatric disorders.

### The Suicidal Patient

Suicide, which must always be anticipated in depressed or delirious persons and in acutely psychotic patients, is a true psychiatric emergency. To recognize these psychic disorders is to anticipate attempted self-destruction. As many clues as are available must be sought and utilized to differentiate the threat of suicide as a dramatic manipulatory device from the likelihood of its occurrence. A depressed patient shows a decrease in psychic and motor activity, a feeling of hopeless despair and a withdrawal of interest. He talks of suicide, speaks of remorse and has feelings that his family is better off without him. He is unable to plan for the future, is indecisive and feels lost. He is self-depreciatory and

very early complains of loss of appetite. He sleeps poorly, awakens early in the morning and is unable to return to sleep. This accounts for many suicidal attempts during the early morning hours. The disturbance in mood is frequently preceded by many vague physical complaints usually indicative of a general slowing up. The element of guilt, self-depreciation and feelings of hopelessness separate this group from the neurotic states with concurrent depressive anxious feelings in which the gesture of suicide is used as a controlling device. By this means such people gain some point in their interpersonal relationships—either affection and solicitude or, perhaps, the release of resentment held towards others. Such patients need not be put in a hospital since, having gained their point through threat or gesture, they are for the time being satisfied.

A depressed, suicidal patient, however, should be put in a hospital and there every precaution must be taken against the possibility of self-destruction. Such a patient needs to be on the ground floor or first floor of a closed, screened hospital unit or with special nurses if adequate closed facilities are unavailable. Special nurses are helpful, since such personnel act as parental substitutes, giving adequate attention and solicitude as compensation for injured self-depreciatory feelings. Direct questioning need not be avoided. Questions should be frankly concerned with the patient's spirits, the presence of thoughts of death, his wish to live or die, his ability to face and plan for the future. The physician frequently is reluctant to ask such direct questions lest he offend the sensitivity of the patient; but more frequently such reservations may be based on his own fears and the misconception that direct questions may implant ideas of suicide.

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